Best Practices for Comprehensive Tobacco Control Programs

Tobacco use is the single most preventable cause of death and disease in our society. Data from California and Massachusetts have shown that implementing comprehensive tobacco control programs produces substantial reductions in tobacco use.

The goal of comprehensive tobacco control programs is to reduce disease, disability, and death related to tobacco use by

- Preventing the initiation of tobacco use among young people.
- Promoting quitting among young people and adults.
- Eliminating nonsmokers' exposure to environmental tobacco smoke (ETS).
- Identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

In this guidance document, CDC recommends that States establish tobacco control programs that are comprehensive, sustainable, and accountable. This document draws upon "best practices" determined by evidence-based analyses of comprehensive State tobacco control programs.

Evidence supporting the programmatic recommendations in this guidance document are of two types. Recommendations for chronic disease programs to reduce the burden of tobacco-related diseases, school programs, cessation programs, enforcement, and counter-marketing program elements are based primarily upon published evidence-based practices. Other program categories rely mainly upon the evidence of the efficacy of the large-scale and sustained efforts of two States (California and Massachusetts) that have been funding comprehensive tobacco prevention and control programs using State tobacco excise taxes.

Based upon this evidence, specific funding ranges and programmatic recommendations are provided. The local analysis of each State's priorities should shape decisions regarding funding allocations for each recommended program component. The funding required for implementing programs will vary depending on state characteristics, such as demographic factors, tobacco use prevalence, and other factors. Although the type of supporting evidence for each of the recommended nine program components differs, evidence supports the implementation of some level of activity in each program area. In general, States typically have selected a funding level around the middle of the recommended ranges. Current allocations range from $2.50 to over $10; however, no State is currently implementing all of the recommended program components fully. Approximate annual costs to implement all of the recommended program components have been estimated to range from $7 to $20 per capita in smaller States (population under 3 million), $6 to $17 per capita in medium-sized States (population 3 to 7 million), and $5 to $16 per capita in larger States (population over 7 million).

The best practices address nine components of comprehensive tobacco control programs:

I. Community Programs to Reduce Tobacco Use (Base funding of $850,000–$1.2 million per year for State personnel and resources; $0.70–$2.00 per capita per year for local governments and organizations).
Local community programs cover a wide range of prevention activities including engaging youth in developing and implementing tobacco control interventions; developing partnerships with local organizations; conducting educational programs for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel, and others; and promoting governmental and voluntary policies to promote clean indoor air, restrict access to tobacco products, provide coverage for treatment, and achieve other policy objectives. In California and Massachusetts, local coalitions and programs have been instrumental in achieving policy and program objectives. Program funding levels range from approximately $1.00 per capita in California to over $2.50 per capita in Massachusetts.

II. Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases ($2.8 million–$4.1 million per year).
Even if current tobacco use stopped, the residual burden of disease among past users would cause disease for decades to come. As part of a comprehensive tobacco control program, communities can focus attention directly on tobacco-related diseases both to prevent them and to detect them early. The following are examples of such disease programs and recommended funding levels:

- Cardiovascular disease prevention ($500,000 for core capacity and $1–$1.5 million for a comprehensive program).
- Asthma prevention (base funding of $200,000–$300,000 and $600,000–$800,000 to support initiatives at the local level).
- Oral health programs ($400,000–$700,000).
- Cancer registries ($75,000–$300,000).

III. School Programs ($500,000–$750,000 per year for personnel and resources to support individual school districts; $4–$6 per student in grades K–12 for annual awards to school districts).
School program activities include implementing CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, which call for tobacco-free policies, evidence-based curricula, teacher training, parental involvement, and cessation services; implementing evidence-based curricula identified through CDC's Research to Classroom Project; and linking school-based efforts with local community coalitions and statewide media and educational campaigns. Oregon has developed a new funding model for school programs based upon CDC's guidelines and experience in California and Massachusetts. At an annual funding level of approximately $1.60 per student, Oregon was able to provide grants to approximately 30% of their school districts. Assuming 100% coverage of school districts using a funding model similar to the Oregon model, $4–$6 per student in grades K–12 should be budgeted.

IV. Enforcement ($150,000–$300,000 per year for interagency coordination; $0.43–$0.80 per capita per year for enforcement programs).
Enforcement of tobacco control policies enhances their efficacy by deterring violators and by sending a message to the public that community leaders believe that these policies are important. The two primary policy areas that require enforcement activity are restrictions on minors' access to tobacco and on smoking in public places. State efforts should be coordinated with Food and Drug Administration (FDA) and Substance Abuse and Mental Health Services Administration (SAMHSA) Federal programs. California and Massachusetts have addressed enforcement issues as part of community program grants. Florida has taken a more centralized approach by using State Alcoholic Beverage Control Officers to conduct compliance checks with locally recruited youth in all regions of the State.

V. Statewide Programs (Approximately $0.40–$1 per capita per year).
Statewide projects can increase the capacity of local programs by providing technical assistance on evaluating programs, promoting media advocacy, implementing smokefree policies, and reducing minors' access to tobacco. Supporting organizations that have statewide access to racial, ethnic, and diverse communities can help eliminate the disparities in tobacco use among the State's various population groups. Statewide and regional grants to organizations representing cities, business and professional groups, law enforcement, and youth groups inform their membership about tobacco control issues and encourage their participation in local efforts. Both California and Massachusetts have awarded grants to statewide organizations, businesses, and other partners that total about $0.40 to $1.00 per capita per year.

VI. Counter-Marketing ($1–$3 per capita per year).
Counter-marketing attempts to counter pro-tobacco influences and increase pro-health messages and influences throughout a State, region, or local community. Counter-marketing consists of a wide range of efforts, including paid television, radio, billboard, and print counter-advertising at the State and local level; media advocacy and other public relations techniques using such tactics as press releases, local events, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. Counter-marketing activities can promote smoking cessation and decrease the likelihood of initiation. They also can have a powerful influence on public support for tobacco control interventions and set a supportive climate for school and community efforts. Counter-marketing campaigns are a primary activity in all States with comprehensive tobacco control programs. With funding levels ranging from less than $1.00 per capita up to almost $3.00 per capita, the campaigns in California, Massachusetts, Arizona, and Florida have been trendsetters in content and production quality.

VII. Cessation Programs ($1 per adult to identify and advise smokers about tobacco use; $2 per smoker to provide brief counseling; and the cost of a full range of cessation services including pharmaceutical aids, behavioral counseling, and follow up visits

($137.50 per served smoker covered by private insurance; $275 per served smoker covered by publicly financed insurance).
Strategies to help people quit smoking can yield significant health and economic benefits. Effective cessation strategies include brief advice by medical providers, counseling, and pharmacotherapy. In addition, system changes (e.g., tobacco-use screening systems, clinician training, and insurance coverage for proven treatments) are critical to the success of cessation interventions. State action should include establishing population-based treatment programs such as telephone cessation helplines; covering treatment of tobacco use under both public and private insurance; and eliminating cost barriers to treatment for underserved populations, particularly the uninsured. No State currently is fully implementing the Agency for Health Care Policy and Research smoking cessation guidelines. Massachusetts and California are implementing the basic recommended elements. The complete recommended program is being implemented in several large health maintenance organizations around the country.

VIII. Surveillance and Evaluation (10% of total annual program costs).
A surveillance and evaluation system monitors program accountability for State policymakers and others responsible for fiscal oversight. Surveillance is the monitoring of tobacco-related behaviors, attitudes, and health outcomes at regular intervals of time. Program evaluation efforts build upon surveillance systems by linking statewide and local program efforts to progress in achieving intermediate and primary outcome objectives. Experience in California, Massachusetts, and other States has demonstrated that the standard public health practice guideline of devoting 10% of program resources to surveillance and evaluation is a sound recommendation. State surveillance efforts should be coordinated with Federal tobacco surveillance programs such as SAMHSA's National Household Survey on Drug Abuse.

IX. Administration and Management (5% of total annual program costs).
An effective tobacco control program requires a strong management structure to facilitate coordination of program components, involvement of multiple State agencies (e.g., health, education, and law enforcement) and levels of local government, and partnership with statewide voluntary health organizations and community groups. In addition, administration and management systems are required to prepare and implement contracts and provide fiscal and program monitoring. Experience in California and Massachusetts has demonstrated that at least 5% of program resources is needed for adequate staffing and management structures.